



RAHM EMANUEL, MAYOR

CITY OF CHICAGO



MEDICAL AND DENTAL PLAN SUMMARY GUIDE FOR 2015

For Sworn Police Officers below the rank of Sergeant represented by the Fraternal Order of Police (FOP)

PPO MEDICAL PLAN COMPARISON



BlueCross BlueShield
of Illinois

1-800-772-6895

www.bcbsil.com

PLAN B

	PPO	
	<i>In-Network</i>	<i>Out-of-Network</i>
MEDICAL BENEFITS		
The Plan pays the following percentage of PPO allowable charges after you meet the calendar year deductible.		
Individual Deductible	\$350	\$1,500
Family Deductible Each Year	\$1,050	\$3,000
Individual Out-of-Pocket Limit Each Year	\$1,500	\$3,500
Family Out-of-Pocket Limit Each Year	\$3,000	\$7,000
Network and Non-Network Provider benefits cannot be combined; does not include prescription copayments		
WELLNESS BENEFIT		
Routine Physical Checkups (Adults)	100% of maximum allowable charges up to \$600 per covered individual, per year Annual routine pap smear, mammogram, PSA and DRE are payable at 100% of the PPO allowable charges, and do not apply toward the Wellness Benefit limit.	
Routine Pediatric Checkups, Well Baby Care & Pre-school exams		
Immunizations		
Routine Lab Work		
Hearing Screenings		
OUTPATIENT PHYSICIAN SERVICES		
Office Visits	90%	60%
Diagnostic Testing (i.e., x-ray, lab, etc.)		
Outpatient Surgery		
Physical Therapy		
Chiropractic Visits - 20 per year max, three modalities per visit		
MRI, PET Scans, CAT Scans		
(Pre-determination of medical necessity is highly recommended. Call Telligen 1-800-373-3727.)		
Durable Medical Equipment (DME) (Call Telligen 1-800-373-3727) ⁽¹⁾		
Skilled Home Health Care and Hospice Care (Call Telligen 1-800-373-3727) ⁽²⁾		
Infertility Treatment (Call Telligen 1-800-373-3727) ⁽²⁾		
Mental Health and Substance Abuse Treatment (Call Telligen 1-800-373-3727) ⁽³⁾	90%	
Occupational Therapy and Speech Therapy (Call Telligen 1-800-373-3727) ⁽⁴⁾		
Ambulance Transportation Between Hospitals (Call Telligen 1-800-373-3727) ⁽⁵⁾	90%	

(1) (if cost of equipment exceeds \$500)

(2) (before services are provided)

(3) (after 7th visit)

(4) (after 10th visit.)(Restoration of function only)

(5) (before hospital transfer)

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BENEFITS FOR 2015

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Important Note: If you were hired on or after January 1 2006, you are not eligible to change your medical or dental plan until the first Open Enrollment Period following 18 months of your City of Chicago date of hire.

PLAN B

	PPO	
	In-Network	Out-of-Network
HOSPITAL		
Room and Board (Private room is covered if medically necessary)**	90%	60%
Number of days (Subject to Medical Necessity)**		
Inpatient Hospital Services**		
Outpatient Hospital Services		
Skilled Nursing Facility**		
MATERNITY		
Delivery**, including prenatal & postnatal visits	90%	60%
INPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT		
Inpatient Mental Health**	90%	60%
Inpatient Substance Abuse Treatment**		
EMERGENCY		
Emergency Room Copayment (waived if admitted) \$100; copayment cannot be applied toward deductible or out-of-pocket expense**		
Emergency Medical Care	90%	90%
Emergency Accident Care		
PRESCRIPTION DRUGS		
Retail (Short term medications) Purchased at a participating pharmacy 34-day supply or 100 units	Generic: \$10.00 co-pay †Brand Name (Formulary): \$30.00 co-pay †Brand Name (Non-Formulary): \$45.00 co-pay (†If the member chooses brand when a generic is available, member pays the cost difference between the brand name and the generic drug PLUS the generic co-pay)	
Mail Order (Long-term medications for chronic conditions) 90 day supply	Generic: \$20.00 co-pay †Formulary Brand: \$60.00 co-pay (†If the member chooses brand when a generic is available, member pays the cost difference between the brand name and the generic drug PLUS the generic co-pay) Important Note: Non-formulary drugs are not available through mail order. If there is no generic or alternative brand name formulary medication on the primary/preferred drug list, you may be able to purchase your medication through the mail order program.	

** All inpatient confinements (hospitalizations) must be precertified. Call Telligen at 1-800-373-3727.

This is a summary of material modifications. The terms of the plan document and any subsequent summary material modifications control.



BENEFITS FOR 2015 DAVIS VISION CARE



PPO MEDICAL PLAN

BLUE ADVANTAGE HMO (A BLUE CROSS HMO)

1-888-456-8758
www.davisvision.com

Plan Benefit		Member Pays
IN-NETWORK		
	Once every:	
Eye Exam	12 months	\$0
Frames	12 months	
Exclusive collection of frames		\$0
\$50 In-network allowance, (in lieu of purchasing from exclusive collection of frames)		Balance over \$50
\$110 In-network allowance at area Visionworks Stores		Balance over \$110
Lenses (per pair)	12 months	
Standard		
Plastic or glass single vision, bifocal, or multifocal types, in any prescription		\$0
Oversized lenses		\$0
Polycarbonate lenses*		\$0
Glass gray #3 prescription lenses		\$0
Contact lenses (in lieu of glasses)	12 months	\$0
Plan contact lenses		\$0
In-Network Allowance for non-plan contacts		Balance over \$105
Optional		
Ultraviolet coating		\$0
Scratch resistant coating		\$18
Standard anti-reflective coating ARC		\$31
Premium anti-reflective coating		\$43
Ultra anti-reflective coating		\$60
Fashion and gradient tinting of plastic lenses		\$0
Polycarbonate lenses (Adult)		\$27
Blended segment lenses		\$0
Corning Photochromic Lenses		\$0
Intermediate Vision Lenses		\$25
High Index Plastic Lenses		\$50
Plastic Photosensitive Lenses		\$59
Polarized Lenses		\$68
Standard progressive addition lenses (PALs)		\$45
Premium Progressive Additional Lenses		\$80
OUT-OF-NETWORK		
REIMBURSEMENT SCHEDULE		
	Once every:	
Eye exam	12 months	Balance over \$35
Lenses (per pair)	12 months	
Single		Balance over \$35
Bifocal		Balance over \$50
Trifocal		Balance over \$60
Lenticular		Balance over \$60
Frames	12 months	Balance over \$50
Contact Lenses (in lieu of glasses)	12 months	Balance over \$105

*Polycarbonate lenses covered in full for dependent children, monocular patients and patients with prescriptions >= +/- 6.00 diopters



BENEFITS FOR 2015

BLUE ADVANTAGE HMO (A BLUE CROSS HMO)

1-800-730-8504

www.bcbsil.com

OUTPATIENT CARE IN THE HMO HEALTH CENTER OR HMO PHYSICIAN'S OFFICE

Diagnostic Testing (i.e., x-ray, lab, etc.)	Covered in full
Surgery	Covered in full with \$20.00 co-payment per visit
Routine Physical Checkups (Adults)	Covered in full with \$20.00 co-payment per visit
Routine Pediatric Checkups, Well Baby Care & Pre-school exams	Covered in full with \$20.00 co-payment per visit
Immunizations	Covered in full
Allergy Shots	Covered in full
Hearing Screening	Covered in full
Physical Therapy, Occupational Therapy & Speech Therapy	Sixty (60) combined visits - per calendar year. Covered in full for conditions which, in the judgment of the attending or consulting physicians, are sufficient for significant improvement. These services are provided for restoration of functions only; services for the acquisition of function are not covered.
Podiatry Care	Covered in full with \$20.00 co-payment per visit. Routine foot care and prescriptions for supportive foot devices not covered.
Oral Surgery	Covered in full with \$20.00 co-payment per visit. Services for dental care are not covered unless required due to surgical removal of a tumor, in connection with an injury, or for treatment of malerupted bony impacted wisdom teeth.

INPATIENT CARE IN AN HMO-AFFILIATED HOSPITAL

Hospital Services	Covered in full with \$20.00 co-payment per admission.
Number of Days	Unlimited
Intensive Care & Other Special Units	Covered in full
Doctor Visits	Covered in full
Specialist Visits	Covered with authorization from Primary Care Physician.
Anesthesiologist	Covered in full
Surgery	Covered in full
Prenatal & Postnatal	Covered in full with \$20.00 co-payment per initial visit.
Inpatient (semi-private room)	Covered in full (Private room covered in full if medically necessary)

MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT

Mental Health Outpatient Visits	Covered in full with \$20.00 co-payment per visit.
Mental Health Inpatient Care	Covered in full with \$20.00 co-payment per admission.
Substance Abuse/Chemical Dependency Treatment - Outpatient Visits	Covered in full with \$20.00 co-payment per visit.
Substance Abuse/Chemical Dependency Treatment -Inpatient Care	Covered in full with \$20.00 co-payment per admission.

EMERGENCY CARE

A medical emergency is the sudden and unexpected onset of a potentially dangerous situation which, if not treated immediately, could jeopardize the patient's health. Such conditions are always severe, sudden in onset and involve one of the major organs of the body.

Provided in full at Primary Care Physician's office or emergency room. If possible, contact your Primary Care Physician first. Your Primary Care Physician is available 24 hours a day, seven days a week. In a life-threatening emergency, call your Primary Care Physician within 48 hours following emergency treatment.

Emergency Room Treatment (Life Threatening)	\$100 Emergency room co-payment (Waived if patient is admitted)
Ambulance (Life Threatening)	Covered in full
Acute Medical Problems (Non-Life Threatening)	Covered in full. Doctors are on call 24 hours a day, seven days a week. Call the emergency number on your ID card or your Primary Care Physician. The physician or nurse will listen to your problem, instruct you to come in for care or direct you to a participating medical facility.

PRESCRIPTIONS

Retail - 30-day supply (Short-term medication)	Generic: \$10.00 co-pay *Brand Name (Formulary): \$30.00 co-pay *Brand Name (Non-Formulary): \$45.00 co-pay (*If the member chooses brand when a generic is available, member pays the cost difference between the brand and the generic drug PLUS the generic co-pay) Important Note: Generic or brand name drugs not included on the formulary are not available through mail order.
Mail Order (Long-term medication for chronic conditions) 90 day supply	Member co-payments are two times the cost of retail co-payments. (If the member chooses brand when a generic is available, member pays the cost difference between the brand and the generic drug PLUS the generic co-pay). \$20.00 (Generic) \$60.00 (Formulary brand) Important Note: Non-formulary drugs are not available through mail order. If there is no generic or alternative brand name formulary medication on the primary/preferred drug list, you may be able to purchase your medications through the mail order program.
Oral Contraceptives (90 day supply)	Covered in full with co-payment

ADDITIONAL SERVICES

Prosthetic Devices	Covered in full	Durable Medical Equipment (DME)	Covered in full
Blood		Infertility Treatment	
Home Health Services		Skilled Nursing Facility	Covered in full, up to 120 days per calendar year.

Benefits Outside The Service Area:

Urgent Care is covered while traveling out-of-state for unexpected illness and injury. When medical services are needed away from home, call our easy to remember toll-free number and we'll quickly put you in touch with an Away From Home Coordinator near your location. The Coordinator will schedule an appointment for you, give you directions and help take the fear out of being sick away from home.

Guest Membership is provided at an affiliated HMO if you or a covered dependent travels away from the service area for at least 90 days. Whether the reason is extended out-of-town business, semesters at school or families living apart, you can still enjoy the full range of benefits offered by the affiliated HMO near your travel destination. Co-payments may differ.

Covered in full means a service is covered to the full extent required by the City and its agreement with the HMO. In some instances, there may be limits on frequency of service. All services listed for the HMOs must be authorized in advance by Plan Physicians in order to be covered. **This HMO Benefit Highlight Sheet describes eligibility and benefits available for the 2015 plan year. It is only to be used as a guide. Please refer to specific benefit booklets available from the HMO for more detailed information.**



BENEFITS FOR 2015

DENTAL PLAN COMPARISON

BlueCare DentalSM www.bcbsil.com/cityofchicago 1-855-557-5487	DENTAL HMO PLAN	DENTAL PPO PLAN	
BENEFIT DESIGN	MUST USE PANEL DENTISTS	IN-NETWORK	OUT-OF-NETWORK
Individual Deductible	\$0	\$100 per person, per year effective 1/1/06	\$200 per person, per year effective 1/1/06
Annual Maximum Benefit*	Unlimited	\$1,200 per person, effective 1/1/02	\$1,200 per person, effective 1/1/02
ORTHODONTIC PROCEDURES (Braces)			
	<i>Co-payment (Member pays)</i>	Not Covered	
Sworn Police and Uniformed Firefighters (Under Age 25 only) All Others (Under Age 19 only)	Effective 1/1/06 \$2,300		
PREVENTIVE SERVICES			
*The Annual Maximum \$1,200 Benefit does not apply to Preventive Services received by children under age 19 enrolled in the Dental PPO Plan.			
Oral Exams (twice a year) Cleanings (twice a year) X-Rays (twice a year)	100% Covered in full (no deductible) \$10 Co-payment required for each preventive service office visit.	100% Covered in full (no deductible) \$10 Co-payment required for each preventive service office visit.	Plan pays 80% of PPO allowable amount (no deductible). Member pays balance of billed charges.
BASIC PROCEDURES		Deductible Applies	
	<i>Co-payments (Member pays)</i> Effective 1/1/07		
Amalgam (Fillings) - one surface permanent	\$20	Plan pays 60% of PPO allowable amount. Member pays 40% of PPO allowable amount.	
Resin - one surface anterior including acid etch-	\$24		
Pin Retention (per tooth) - in addition to restoration	\$31		
Routine Extraction Single Tooth	\$24		
Surgical Removal of Erupted Tooth	\$45		
Surgical Removal of Tooth - soft tissue impaction	\$58		
Surgical Removal of Tooth - partial bony impaction	\$83		
Surgical Removal of Tooth - complete bony impaction	\$83		
Alveoloplasty - without extractions - per quadrant	\$96		
Scaling and Root Planing - per quadrant with local anesthesia	\$45		
Gingivectomy or Gingivoplasty - per quadrant	\$183		
Gingival Flap Procedure Including Root Planing - per quadrant	\$175		
Osseous Surgery, Flap Entry and Closure - per quadrant	\$203		
Pulp Capping (direct or indirect)	\$15		
Root Canal Therapy anterior	\$149		
bicuspid	\$160		
molar	\$215		
Apicoectomy - (first root)	\$138		
Palliative Treatment	\$17		
Limited Occlusion Adjustment	\$26		
MAJOR RESTORATIVE PROCEDURES		Plan pays 50% of PPO allowable amount. . Member pays balance of billed charges.	
Inlay - metallic (one surface)	\$276		
Onlay - metallic (three surfaces)	\$373		
Core Buildup Including Pins	\$110		
Crown repair	\$85		
Crown - porcelain/ceramic substrate	\$385		
Crown - fused to high noble metal	\$395		
Denture - complete upper or lower	\$485		
Lower Denture Reline - chairside	\$147		

To obtain a current list of dentists in either the HMO or PPO plan, please contact BlueCare. The website and customer service phone number are listed at the top of this chart. **Important Note: This comparison provides only the highlights of the programs. Specific details are contained in the plan document booklet. If conflict arises between this material and any plan provisions, the terms of the actual Plan documents or other applicable documents will govern in all cases.**



CITY OF CHICAGO



2015 IMPORTANT WEB SITES AND TELEPHONE NUMBERS

Plan Eligibility and Benefit Coverage	City of Chicago Benefits Service Center	www.cityofchicagobenefits.org	1-877-299-5111	
Medical Plans				
PPO Plan			1-800-772-6895	(For Claims Processing) 300 East Randolph Street Chicago, IL 60601-5099
Blue Advantage HMO	Blue Cross Blue Shield of Illinois	www.bcbsil.com	1-800-730-8504	
Medical Plan Prescriptions				
Blue Advantage HMO	Blue Cross Blue Shield of Illinois	www.bcbsil.com	1-800-423-1973	(For Claims Processing) 300 East Randolph Street Chicago, IL 60601-5099
PPO Plan	CVS Caremark	www.caremark.com	1-866-748-0028	(For Mail Order Prescriptions) P.O. Box 94467 Palatine, IL 60094-4467 (For Claims Processing) P.O. Box 686005 San Antonio, TX 78268-6005
Medical Plan Advisor				
PPO Plan	Telligen	http://telligen.qualitrac.com	1-800-373-3727	1776 Westlakes Parkway West Des Moines, IA 50266-7771
Dental Plans				
Dental HMO & Dental PPO	BlueCare Dental	www.bcbsil.com/cityofchicago	1-855-557-5487	(For Claims Processing) P.O. Box 23059 Belleville, IL 62223-0059
Vision Care Benefits				
PPO Plan				175 East Houston Street San Antonio, Tx 78205
Blue Advantage HMO	Davis Vision	www.davisvision.com	1-888-456-8758	
Flexible Spending Account				
	PayFlex (FSA)	www.HealthHub.com	1-800-284-4885	Flex Dept PO Box 3039 Omaha, NE 68103-3039
Life Insurance Plans				
Term Life Insurance	Prudential Insurance Company of America	www.prudential.com	1-800-778-3827	PO Box 13676 Philadelphia, PA 19176 Attn: Rebecca Wanner
Universal Life Insurance	MetLife Underwritten by TexasLife	http://empben/CityofChicagoUL/Welcome.html	1-800-638-6855	2650 Warrenville Rd, Suite 100 Downers Grove, IL 60515
Long Term Disability				
	Prudential Insurance Company of America	www.prudential.com	1-800-778-3827	PO Box 13676 Philadelphia, PA 19176 Attn: Rebecca Wanner
Deferred Compensation				
	Nationwide Retirement Solutions	www.chicagodeferrredcomp.com	1-855-457-2489 1-877-677-3678	205 W. Randolph Street, Suite 1540 Chicago, IL 60606-1814
Transit Benefit				
	Wageworks	www.wageworks.com	1-877-924-3967	1100 Park Place San Mateo, CA 94403
Pension Funds				
Uniformed Firefighters	Firemen's Annuity and Benefit Fund of Chicago	www.fabf.org	1-312-726-5823	20 South Clark Street, Room 1400 Chicago, IL 60603
Sworn Police	Policemen's Annuity and Benefit Fund of Chicago	www.chipabf.org	1-312-744-3891	221 N. LaSalle Street, Suite 1626 Chicago, IL 60601-1206
Municipal Employees	Municipal Employees' Annuity and Benefit Fund of Chicago (MEABF)	www.meabf.org	1-312-236-4700	321 N. Clark Street, Room 700 Chicago, IL 60654-4767
Laborer Employees	Laborers' and Retirement Board Employees' Annuity and Benefit Fund of Chicago	www.labfchicago.org	1-312-236-2065	321 N. Clark Street, Room 1300 Chicago, IL 60654-4767